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- ADMITTED IN RHODE ISLAND ONLY

VIA FIRST CLASS MAIL

April 14, 2006

Flavia Benitez  
PO Box 2437  
Jamaica Plain, MA 02130

RE: Flavia Benitez v. Sodexho Marriott Services  
U.S. District Court, Civil Action No.: 04-CV-11959-NG

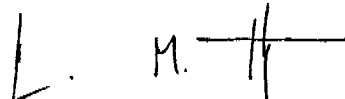
Dear Ms. Benitez:

Enclosed please find an Authorization to Obtain, Use and Disclose Protected Health Information from Cambridge Health Alliance / Cambridge Hospital. Cambridge Health Alliance / Cambridge Hospital will not release any of your records until this enclosed form is signed by you and returned to them. As such, I ask that you please sign the enclosed form and return to me on or before April 21, 2006.

Although the Authorization to Disclose Information that you signed on March 23, 2006, was sent to the Cambridge Health Alliance / Cambridge Hospital, the facility informed me that this Authorization was not sufficient to obtain the release of your records. The facility stated that unless it receives either an executed version of the enclosed form, or a court order, your records will not be released.

Should you have any questions or concerns, please do not hesitate to contact me. Thank you for your anticipated cooperation in this matter.

Very truly yours,

  
Brian M. Haney

enclosure



# THE CAMBRIDGE HEALTH ALLIANCE

**AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION**  
Request for Copies of Medical Records ☒ Request to Review Medical Records ☐

Medical Record # \_\_\_\_\_

Patient Name: Benitez

Home Address: Last First Middle  
PO Box 2437 Jamaica Plain  
State: MA ZIP: 02130

Home Telephone: (508) 345-5380 Date of Birth: 10/05/1954

I authorize (name of hospital/person) Cambridge Health Alliance/  
☒ Disclose to Cambridge Hospital to: ☐ Obtain from  
☐ Communicate with

Name/Facility: Cooley Manion Jones LLP

Address: 21 Custom House Street, Boston

State: MA ZIP: 02110 Phone: (617) 737-3100 Fax: (617) 737-0374

Attention: ~ Brian Haney, Esq.; Keith McLean, Esq.; Ken Martin, Esq.

Disclose the following information for treatment dates January 1, 1996 to Present

- ☒ Entire Medical Record OR
- ☐ Face Sheet ☐ Admission Note ☐ History & Physical ☐ Progress Notes
  - ☐ Consults ☐ Lab Reports ☐ Pathology Reports ☐ X-ray/Scan/Imaging Reports
  - ☐ Operative Reports ☐ Emergency Reports ☐ Physical Therapy Notes ☐ Clinic Notes
  - ☐ Medication Notes ☐ Treatment Plan ☐ Discharge Summary
  - ☐ Abstract (Discharge Summary, History & Physical, Operative, Pathology & Test Reports)
  - ☐ Other \_\_\_\_\_

The purpose of this disclosure is: ☐ Medical Care ☒ Legal Matter ☐ Insurance ☐ Personal  
☐ Other \_\_\_\_\_

TERM: This Authorization expires /terminates/ends:  
☒ 90 days from the date signed ☐ On Other date, reason or event \_\_\_\_\_

By my signature below, I hereby authorize Cambridge Health Alliance to obtain, use and/or disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).  
I understand that once Cambridge Health Alliance discloses my health information to the recipient, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.  
I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Cambridge Health Alliance's treatment of me; except, however, if my treatment at Cambridge Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Cambridge Health Alliance may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cambridge Health Alliance's Privacy Office at the address listed below. The revocation will be effective immediately upon Cambridge Health Alliance's receipt of my written notice, except that

Revocation will have any effect on any action taken by Cambridge Health Alliance in reliance on this Authorization before it received my written notice of revocation.

I may contact Cambridge Health Alliance's Privacy Officer by mail at 432 Columbia St. Suite 15/16C Cambridge, MA 02141 or through any of CHA hospital's H.I.M. Departments (listed at the bottom of the page).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cambridge Health Alliance to obtain, use and/or disclose my health information in the manner described above.

X

Signature of Patient

Date

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of  
Personal Representative

Description of  
Authority

Date

### MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below, I specifically authorize obtaining, using and/or disclosing the type of highly confidential information indicated next to my signature. If any such information will be obtained, used or disclosed pursuant to this Authorization.

- Information about a Mental Illness, Behavioral Health or Developmental Disability \_\_\_\_\_
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional \_\_\_\_\_
- Information about HIV/AIDS Testing, Status or Treatment \_\_\_\_\_  
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s) Status or Treatment \_\_\_\_\_
- Information about Substance (i.e., alcohol or drug) Abuse Status or Treatment \_\_\_\_\_
- Information about Abuse of an Adult with a Disability \_\_\_\_\_
- Information about Sexual Assault \_\_\_\_\_
- Information about Child Abuse and Neglect \_\_\_\_\_
- Information about Genetic Testing \_\_\_\_\_
- Information about abortion \_\_\_\_\_
- Information about mammography \_\_\_\_\_
- Information about family planning services \_\_\_\_\_
- Information related to mental health community program records \_\_\_\_\_
- Information about research involving controlled substances \_\_\_\_\_
- Information about domestic violence \_\_\_\_\_
- If I am an emancipated minor, information about treatment and diagnosis (except to my parents) \_\_\_\_\_

DATE: \_\_\_\_\_

The Cambridge Hospital  
1493 Cambridge Street  
Cambridge, MA 02139

HIM Department  
Release of Information Section  
617-665-1058

Somerville Hospital  
230 Highland Avenue  
Somerville, MA 02143

HIM Department  
Release of Information Section  
617-591-4127

Whidden Memorial Hospital  
103 Garland St.  
Everett, MA 02149

HIM Department  
Release of Information Section  
617-381-7127